State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P. O. Box 2590
Fairmont, WV 26555

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

November 25, 2009

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held October 29, 2009. Your hearing request was based on the Department of Health and Human Resources' action to deny your application for Medicaid Long-Term Care (Nursing Facility) benefits.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

Eligibility for Medicaid, Long Term Care (Nursing Facility) Services is based on current policy and regulations and requires eligible individuals to meet both medical and financial criteria. To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The Bureau has designated a tool known as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit.

Information submitted at your hearing demonstrates that your medical condition requires a sufficient number of services and the degree of care necessary to qualify you for nursing facility level of care.

It is the decision of the State Hearing Officer to **reverse** the Department's action in denying your application for Medicaid Long-Term Care benefits based on medical eligibility.

Sincerely,

Thomas E. Arnett
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
-----, LSW, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

-----,

Claimant,

v. **Action Number: 09-BOR-1643**

West Virginia Department of Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on November 25, 2009 for -----. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened October 29, 2009 on a timely appeal filed August 3, 2009.

II. PROGRAM PURPOSE:

Nursing Home Care is a medical service, which is covered by the State's Medicaid Program. Payment for care is made to nursing homes, which meet Title XIX standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet both financial and medical eligibility criteria.

III. PARTICIPANTS:

-----, Claimant
-----, Director of Social Services, [redacted] Nursing Home
-----, RN, [redacted] Nursing Home (Participated telephonically)
-----, LSW, Bureau for Medical Services (BMS) (Participated telephonically)
Joyce Romeo, RN, West Virginia Medical Institute (WVMI) (Participated telephonically)

Presiding at the hearing was Thomas E. Arnett, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct in determining that the Claimant fails to meet the medical eligibility criteria for participation in the Medicaid Long-Term Care (Nursing Facility) Program.

V. APPLICABLE POLICY:

West Virginia Medicaid Manual, Chapter 500, Section 514

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

Exhibit 1	WV Medicaid Manual, Chapter 500, Section 514, 514.8.1, 514.8.2 (pages 1-3)
Exhibit 2	Pre-Admission Screening (PAS) form dated July 1, 2009 (pages 4-9)
Exhibit 3	Notice of Denial Determination by WVMI dated July 3, 2008 (pages 10)
Exhibit 4	Supporting Documentation (Pages 11-26)

Claimant's Exhibits:

Claimant's-1	Resident Notes Report 10/1/09 – 10/31/09

VII. FINDINGS OF FACT:

1) In response to a Pre-Admission Screening (PAS) form completed on July 1, 2009 (Exhibit 2), the Claimant was notified that her application for Medicaid Long-Term Care benefits was denied (Exhibit 3). The July 10, 2009 notice states, in pertinent part:

> **NOTICE:** YOUR REQUEST FOR LONG-TERM CARE (NURSING HOME) ADMISSION HAS BEEN DENIED.
>
> An evaluation of your current limitations related to your medical condition(s) was conducted based on the information submitted to WVMI on the Pre-Admission Screening (PAS) form. It has been determined you are ineligible for long-term care (nursing home) admission based upon WV Medicaid criteria.
>
> **REASON FOR DECISION:** Eligibility for long-term care placement being funded by Medicaid requires that you have at least five (5) areas of care needs (deficits) that meet the severity criteria. Documentation does not reflect that you have 5 deficits at the level required. Your request for long-term care is being denied. The PAS (Pre-Admission Screening Form), reflected deficiencies that meet the severity criteria in 2 areas identified below – Bathing and Administering Medications.

2) The Department cited Medicaid regulations and called its witness to explain how Medicaid policy was applied to the medical findings documented on the Claimant's PAS completed on July 1, 2009 (Exhibit 2). According to Joyce Romeo, RN, WVMI, the Claimant's physician completed the medical assessment and his documentation was relied upon by WVMI to identify qualifying deficits. Consistent with Exhibit-3, the Department stipulated that the Claimant is demonstrating two (2) functional deficits – bathing and administering medications. However, because the required five (5) deficits were not identified, medical eligibility for continued participation in the Medicaid Long-Term Care Program could not be established.

3) The Claimant is an 89-year-old female who presents a diagnosis of Congestive Heart Failure, Dysthymic Disorder (Depression) and was admitted to [redacted] Nursing Home with a diagnosis of Adult Failure to Thrive. ----- (Director Social Services at [redacted] and ----- (RN, [redacted] testified the Claimant's health has improved since she was admitted in December 2008, however, they contend the Claimant continues to require a nursing facility level of care as she demonstrates a deficit in dressing, transferring and vacating [a building in the event of an emergency].

Dressing – The Claimant testified that when she feels bad and is having difficulty breathing, "I have one of the girls help me with dressing." The Claimant further testified that she cannot stand long and that she unable to let go of her walker, or whoever is helping her dress, or she will fall. Based on the evidence, the Claimant requires hands-on physical assistance to dress and a deficit is therefore established.

Transferring – ----- testified that the Claimant fatigues easily due to her medical condition, and as a result, she frequently requires physical assistance (one person assistance) with transferring out of her bed. The Claimant testified that she must also use the rails of her bed to assist with transferring on those occasions when she does not require physical assistance. The actual number of times the Claimant requires physical assistance to transfer out of bed was estimated at one or two times per week, especially when the Claimant is experiencing breathing problems. The evidence supports a finding that the Claimant requires physical assistance to transfer, albeit erratic and dependent on how she feels that day. The Claimant would be unable to manage on a daily basis in the absence of the physical assistance provided at the nursing facility in transferring.

Vacating – Testimony submitted by ----- reveals that the Claimant hearing is impaired, not correctable (See Exhibit-2, page 3 of 6, #26.l) and that the Claimant would likely not hear an alarm to exit the building. In addition to her poor hearing, the Claimant requires physical assistance with transferring and her room is not located near an exit. -----testified that the Claimant would likely fatigue well before reaching the exit and require physical assistance to vacate the building in the event of an emergency.

4) WV DHHR Medicaid, Long Term Care Policy §514.8, states as follows:

The Department has established a process of evaluation to determine eligibility for long term care services under the Medicaid Program. The evaluation is made on each recipient from information supplied by a physician, recipient or family/representative, health care facility and/or eligibility worker in the local Department of Health and Human Resources office. This determination for the Medicaid benefit for nursing facility residents is based on both medical and financial criteria. The Bureau for Medical Services or its designee is responsible for the medical necessity determination and the Bureau of Children and Families is responsible for the financial determination.

The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates:

- The date of application in the local DHHR office;
- The date of the physician signature on the medical assessment tool; or the date of admission to the nursing facility.

The local office is responsible for notifying the individual/representative, the Bureau and the nursing facility of the date Medicaid eligibility begins.

514.8.1 APPLICATION PROCEDURE

An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The application for NF services is made to the local DHHR office. The determination of financial eligibility for Medicaid is the responsibility of the local office; and
- The medical eligibility determination is the responsibility of the Bureau for Medical Services based on a physician's assessment of the medical and physical needs of the individual. This assessment must have a physician signature dated not more than sixty days prior to the start of services.

514.8.2 MEDICAL ELIGIBILITY

To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The Bureau has designated a tool known as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. See Attachment. An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit. These deficits may be any of the following:

- #24: Decubitus - Stage 3 or 4
- #25: In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) and b) are not considered deficits.
- #26: Functional abilities of individual in the home.
  Eating - Level 2 or higher (physical assistance to get nourishment, not preparation)
  Bathing - Level 2 or higher (physical assistance or more)
  Grooming - Level 2 or higher (physical assistance or more)
  Dressing - Level 2 or higher (physical assistance or more)
  Continence - Level 3 or higher (must be incontinent)
  Orientation - Level 3 or higher (totally disoriented, comatose)
  Transfer - Level 3 or higher (one person or two persons assist in the home)
  Walking - Level 3 or higher (one person assist in the home)
  Wheeling - Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home.) Do not count outside the home.
- #27: Individual has skilled needs in one or more of these areas - (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
- #28: Individual is not capable of administering his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed and signed and dated by a physician. It is then forwarded to the Bureau or its designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility no matter what the payment source for services.

Each nursing facility must have an original pre-admission screening tool to qualify the individual for Medicaid and to meet the federal PASRR requirements. Should the receiving nursing facility fail to obtain an approved assessment prior to admission of a Medicaid eligible individual, the Medicaid program cannot pay for services. The individual cannot be charged for the cost of care during the non-covered period.

A Medicaid recipient who converts from Medicare Part A coverage to Medicaid does not need a new assessment to receive the Medicaid benefit. Medicaid coverage can be reinstated as long as a Medicaid denial letter has been issued.

A new medical assessment must be done for Medicaid eligibility for the nursing facility resident for all of the following situations:
- Application for the Medicaid nursing facility benefit;
- Transfer from one nursing facility to another;
- Previous resident returning from any setting other than an acute care hospital;
- Resident transferred to an acute care hospital, then to a distinct skilled nursing unit, and then returns to the original nursing facility; and
- Resident converts from private pay to Medicaid.

VIII. CONCLUSIONS OF LAW:

1) To qualify medically for the Medicaid Long-Term Care Program, policy specifies that an individual must require direct nursing care twenty-four (24) hours a day, seven (7) days a week. A tool known as the Pre-Admission Screening form (PAS) is utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. An individual must have a minimum of five (5) qualifying deficits on the PAS in order to qualify medically. These deficits are derived from a combination of assessment elements on the PAS completed by the evaluating physician.

2) The July 1, 2009 PAS reveals that the Claimant demonstrated two (2) program qualifying deficits – bathing and administering medications.

3) The evidence submitted at the hearing identifies three (3) additional program qualifying deficits in the areas of dressing, transferring and vacating the building [in the event of an emergency].

4) Whereas the Claimant demonstrates five (5) qualifying deficits, the Claimant continues to be medically eligible for participation in the Medicaid Long-Term Care program.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the Department's proposal to terminate the Claimant's Medicaid Long-Term Care (Nursing Facility) benefits.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 25th Day of November, 2009.

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Thomas E. Arnett
State Hearing Officer
Member, State Board of Review